

Added Advantage POSSM Plan

Benefit Summary (For groups 2 to 50)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective July 1, 2010

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLES	Network Benefits ³ : HMO Plan Providers	In PPO Network and Out of PPO Network ³ : Member Use of Plan and Non-Plan Providers ²
Calendar-Year Deductible	None	\$500 per individual/\$1,000 per family
Calendar-year Copayment Maximum ¹	\$2,500 per individual/\$5,000 per family	\$5,000 per individual/\$10,000 per family
LIFETIME MAXIMUM	None	\$2,000,000
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Network Benefits ³ : HMO Plan Providers	In PPO Network and Out of PPO Network ³ : Member Use of Plan and Non-Plan Providers ²
Physician services – outpatient		
<ul style="list-style-type: none"> Physician and specialist office visits Note: For network benefits provider level, a woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services Allergy testing or treatment 	\$25/visit	30%
Laboratory and X-rays	No charge	30%
Preventive care		
<ul style="list-style-type: none"> Routine physical exam, eye/ear screenings and immunizations according to age schedule Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for annual gynecological exams. 	No charge	Not covered
OUTPATIENT SERVICES		
Non-emergency		
<ul style="list-style-type: none"> Outpatient surgery performed in a participating ambulatory surgery center (ASC)⁴ Outpatient surgery in hospital/facility Outpatient treatment (except as described under "Rehabilitative therapy services"), and necessary supplies Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) 	\$350/surgery \$500/surgery No charge \$500/surgery	20% In PPO network 30% ⁵ Out of PPO network 30% ⁵ 30% In PPO network 30% ^{1,5} Out of PPO network 30% ^{5,6}
HOSPITALIZATION SERVICES		
<ul style="list-style-type: none"> Inpatient physician services (including pregnancy and maternity care) Semi-private room and board, medically necessary services and supplies Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) Skilled nursing facility (SNF) services⁷ 	No charge \$500/admission \$500/admission No charge	30% 30% ⁵ 30% ^{5,6} 30% ⁵

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A16053-300-C (7/10)

Covered Services**Member Copayment****EMERGENCY HEALTH COVERAGE**

• Emergency room facility services (ER facility copayment does not apply if the member is admitted directly to the hospital for inpatient services)	\$100/visit	\$100/visit
• Emergency room physician visits	No charge	No charge

AMBULANCE SERVICES

\$50	30%
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PRESCRIPTION DRUG COVERAGE^{8,9}

(Including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

	Participating Pharmacy¹ (For up to a 30-day supply)	Mail Service Prescriptions¹ (For up to a 90-day supply)
• Calendar-year brand-name drug deductible	\$150 per member per calendar-year, applied to brand-name and home self-administered injectable drugs.	
• Generic drugs	\$15/prescription	\$30/prescription
• Formulary brand-name drugs	\$30/prescription	\$60/prescription
• Home self-administered injectable drugs (Medications may require prior authorization from Blue Shield Pharmacy Services; member pays up to \$100 copayment maximum per prescription)	20% of allowed charges	Not covered

PROSTHETICS/ORTHOTICS**Network Benefits³:
HMO Plan Providers****In PPO Network and Out of PPO Network³: Member Use of Plan and Non-Plan Providers²**

• Prosthetic appliances and orthoses benefits (Equipment and devices only. Separate office visit copay may apply.)	No charge	30%
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DURABLE MEDICAL EQUIPMENT (Plan payment up to \$2,000 maximum per person per calendar year)

50% of allowed charges ¹	50%
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MENTAL HEALTH SERVICES (PSYCHIATRIC)¹⁰**MHSA Participating Providers³****MHSA Non-Participating Providers³**

• Inpatient hospital facility services	\$500/admission	30% ⁵
• Outpatient visits for severe mental health conditions	\$25/visit	30%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)	\$50/visit ¹	50% ¹

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)¹⁰, PLEASE SEE FOOTNOTE 11

• Inpatient services for medical acute detoxification	\$500/admission	30% ⁵
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)	\$50/visit ¹	50% ¹

HOME HEALTH SERVICES**Network Benefits³:
HMO Plan Providers****In PPO Network and Out of PPO Network³: Member Use of Plan and Non-Plan Providers²**

• Agency visits (up to 100 visits per calendar year)	\$25/visit	Not covered ¹²
• Medical supplies/IV solutions (For home self-administered injectable drugs, see "Prescription Drug Coverage.")	No charge	Not covered ¹²

OTHER**Hospice**

• Routine home care	No charge	Not covered ⁻¹³
• Inpatient respite care	No charge	Not covered ¹³
• 24 hour continuous home care	\$100/day	Not covered ⁻¹³
• General inpatient care	\$100/day	Not covered ¹³

Covered Services

Member Copayment

Pregnancy and maternity care

Network Benefits³: HMO Plan Providers

In PPO Network and Out of PPO Network³: Member Use of Plan and Non-Plan Providers²

- Prenatal and postnatal professional (physician) services
(For all necessary inpatient hospital services, see "Hospitalization Services.")

No charge

30%

Family planning and infertility

- Family planning counseling
- Diagnosis and treatment of cause of infertility
(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)
- Tubal ligation^{14, 15} and elective abortion¹⁵
- Vasectomy¹⁵

No charge

Not covered

50% of allowed charges

Not covered

\$100

50%

\$75

50%

Rehabilitative therapy services

- Outpatient visits

\$25/visit

30%

(Copayment applies to all places of service including professional and facility settings)

(Up to 12 visits per calendar year for physical therapy and chiropractic services)

Diabetes care

- Equipment, devices and non-testing supplies
(For testing supplies, see "Prescription Drug Coverage.")
- Self-management training and education

50% of allowed charges

50%

\$25/visit

30%

Urgent care outside service area (BlueCard[®] Program)

\$50/visit¹⁶

See Applicable Benefit

Optional Benefits

Optional dental, vision, chiropractic, chiropractic and acupuncture, or infertility benefit is available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the plan contract for exact terms and conditions of coverage.

2 In PPO Network providers consist of plan providers. Out of PPO Network providers consist of non-plan (non-preferred and non-participating) providers.

3 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Plan providers accept Blue Shield's allowable amount as full payment for covered services. Non-plan providers can charge more than these amounts. When members use non-plan providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum. Calendar-year deductible applies to the combined services of In PPO Network and Out of PPO Network plan and non-plan providers.

4 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

5 The maximum allowed charge for non-emergency hospital services received from a non-plan provider-hospital is \$600 per day. Members are responsible for 30 percent of this \$600 per day, plus all charges in excess of \$600.

6 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the *Evidence of Coverage* for further benefit details.

7 Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

8 Only drugs on the Blue Shield Drug Formulary are covered unless prior authorized by Blue Shield Pharmacy Services. If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the Participating Pharmacy contracted rate for the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

9 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

10 Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through Blue Shield's Mental Health Service-Administrator (MHSA) — utilizing Blue Shield's MHSA Participating (Level I) and Non-Participating (Level III) providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. There are no Level II providers for mental health and chemical dependency services, other than for medical acute detoxification. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's HMO Plan Providers (Level I), Preferred Providers (Level II), or Non-Preferred Providers (Level III). For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the Evidence of Coverage or Plan Contract.

11 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as “Additional Substance Abuse Treatment Benefits.”**

12 Out of network home health care services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

13 Out of network hospice is not covered unless pre-authorized. When these services are pre-authorized, the member pays the HMO level copayment.

14 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.

15 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

16 For Level I Services outside of California or the United States, Out-of-Area Follow-up Care is covered through any provider or through the BlueCard® Program participating provider network. However, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. For Level I Services outside your Personal Physician Service Area but within California, Member Services will assist the patient in receiving Out-of-Area Follow-up Care through a Blue Shield Plan Provider. To receive Level I Services, Blue Shield HMO may direct the patient to receive follow-up Services from the Personal Physician.

Plan designs may be modified to ensure compliance with state and federal requirements